Proposals for Changes to Adjudicatory Rules, 452 C.M.R. 1.00 et seq.

Deletions in italics
Additions in Bold

1.02 Definitions

Action against a Third Person as used in M.G.L. c. 152, §41, shall be limited to actions involving injuries for which compensation has been paid or claimed.

Actual Employment as used in M.G.L. c. 152 and 452 CMR 1.00 shall include any job for which the employee receives earnings.

Additional Compensation as used in M.G.L. c. 152, §8(5), shall mean compensation due pursuant to an order or decision finding that prior compensation was illegally discontinued.

Advocate on Behalf of Any Party as used in M.G.L. c. 152, §10B, shall mean any person representing a party in any proceeding before the Industrial Accident Board or Reviewing Board, except where the sole consideration for the representation of any such party is in the form of regular wages or salary from employment with a self-insurer, labor organization, employee association, the Commonwealth or any of its political subdivisions, or any entity which receives no consideration in the form of premiums or fees for services relating to the representation of parties before the Industrial Accident Board or Reviewing Board.

ADD:

All Payments Due an Employee as used in M.G.L. c. 152, Section 8(1), shall mean, in regard to past due or retroactive benefits only, the sum certain payable to the employee after the determination of the amount due a lien holder in satisfaction of any lien filed pursuant to M.G.L. c. 152, Section 46A. Unless otherwise agreed, the parties shall make reasonable efforts to expedite the determination of the amount due the Section 46A lien holder, but in no event shall payment be delayed beyond sixty days of the insurer's receipt of the order, decision, arbitrator's decision, approved lump sum or other agreement indicating that such payments are required to be made. All other payments due an employee shall be made by the insurer within the timeframe set forth in M.G.L. c. 152, Section 8(1).

Purpose: This change in the definition of All Payments Due an Employee is designed to address the difficulty faced by insurers and self-insurers in repaying benefits subject to a lien under Section 46A while making timely payments to an employee under an order, agreement or decision. Problems frequently arise when short-term and long-term disability payments have been made to injured employees. Disability carriers often cannot provide the workers' compensation insurers with the information necessary to calculate the repayment under Section 46A within 14 days of the insurer's receipt of the order, agreement or decision. This change requires insurers to make reasonable efforts to expedite the repayment and any net payment to the employee and sets a limit of 60 days. It only applies to past due or retroactive benefits and in no way relieves an insurer from timely payment of future benefits.

Amount Payable to the Employee Within the First Month from the Date of the Voluntary Payment, Order or Decision as used in M.G.L. c. 152, §13A(10), shall mean any compensation due the employee under the terms of the voluntary payment, order or decision pursuant to M.G.L. c. 152, §36 or §36A and any future weekly benefits pursuant to M.G.L. c. 152 due the employee for the first 30 days subsequent to the date of execution of a voluntary payment or the issuance of an order or decision.

Average Weekly Wage in the Commonwealth as used in M.G.L. c. 152 and 452 CMR 1.00, shall be the wage, as calculated pursuant to M.G.L. c. 152, §1(9), on or most nearly previous to the applicable date.

Cash Award as used in M.G.L. c. 152, §13A(10), shall mean any specific compensation benefits payable under M.G.L. c. 152, §36 or §36A and any weekly benefits payable under M.G.L. c. 152 of an amount that exceeds the weekly amount being paid the employee for the week immediately prior to the date of the voluntary payment, order or decision.

AMEND:

Disputes Over Medical Issues, as used in §11A(2), shall not include any case in which *the parties:*

(a) **the parties** disagree solely regarding the entitlement to weekly benefits concerning a specific period or periods of disability, or death, which occurred prior to the hearing scheduled pursuant to M.G.L. c. 152 § 11;
(b) **the parties** disagree regarding the liability of the named insurer for any claimed injury; provided, however, that the parties agree that no impartial physician's report is required;
(c) *agree upon both the partial nature and the duration of the disability as well as the causal relationship between the disability and the employment; provided, however, that the parties agree that no impartial physician's report is required.*
the parties agree upon both the nature of the impairment and the causal relationship between the impairment and the employment;
(d) based upon the information submitted at a Conference pursuant to § 10A, the administrative judge determines that there is no dispute over medical issues. The judge's determination, and reasons therefor, shall be stated in the Section 10A Conference order.

Purpose: The committee has considered various situations where there may be a dispute over the degree of impairment or incapacity but the area of contention involves non-medical factors such as the employee's age, education, training, work experience or other vocational factors.

Situations arise whereby the parties submit medical reports identifying essentially similar physical restrictions making the need for an impartial medical examination unnecessary; or where one of the parties fails to submit any medical report, relying instead on a sec. 11A impartial medical examination. In both of these situations, an impartial medical examination would neither add anything new to the dispute resolution process nor resolve a dispute between

"dueling doctors," the Legislature's rationale behind the enactment of sec. 11A.

The committee has made a minor language change to subparagraph (c) of the existing Rule 1.02 definition of "Disputes over medical issues," and added a new subparagraph (d) to reflect and address these concerns.

Experience Modified Insured as used in M.G.L. c. 152, §48(1), shall mean any named employer in a proposed lump sum settlement which has an experience modification in effect at the time of the lump sum settlement that, under the terms of a rating plan approved by the commissioner of insurance, could be affected by the proposed lump sum settlement.
Factual Basis for an Insurer's Refusal to Pay Compensation as used in M.G.L. c. 152, §§7 and 8, shall be a short and plain settlement of the specific facts supporting the grounds for said refusal.
Filed as used on M.G.L. c. 152, §§10A and 11C as used in 452 CMR 1.11(1) and 1.15(1) shall mean placement of the appeal in the mail to the Department postmarked no later than midnight on the 14th day when appealing a conference order under M.G.L. c. 152, §10A, and the 30th day when appealing the decision of an administrative judge pursuant to M.G.L. c. 152, § 11C.
Grounds for an Insurer's Refusal to Pay Compensation as used in M.G.L. c. 152, §§7 and 8, shall mean any defense available under M.G.L. c. 152, including but not limited to:

(a) lack of jurisdiction;
(b) late notice;
(c) late claim;
(d) no personal injury;
(e) no injury arising out of and in the course of employment;
(f) no disability; and
(g) no causal relation between personal injury and disability.

Hearing**,** as used in M.G.L. c. 152, §11A(2), shall be restricted to proceedings subsequent to a conference concerning medical disputes as herein defined. All other hearings shall be held in accordance with M.G.L. c. 152, §11 and 452 CMR 1.00.
Hospitalization Expenses as used in M.G.L. c. 152, §(13(1), shall mean any charges for in-patient hospital services adjudged compensable under M.G.L. c. 152.
Insurer as used in M.G.L. c. 152, §45 shall include the Workers' Compensation Trust Fund.

ADD:

Interest as used in as used in M.G.L. c. 152, §50, shall be calculated using the Department-provided formula available on its website. The parties may utilize other formulas but when a discrepancy exists the amount of interest in the Department formula will prevail for all purposes.

Purpose: The proposal aims to standardize the formula for sec. 50 interest, which has been a source of ongoing trouble, as there are numerous formulas in circulation, each of which yields different amounts. The ultimate problem to be rectified relates back to sec. 8(1) penalties, as some attorneys have turned the strict compliance practice under that section into a scheme for capturing $10,000 penalties on underpayment of a few dollars and cents in interest, by using a

different formula than the one utilized by the insurer.

Mid-term Notice of Cancellation as used in M.G.L. c. 152, §55A, shall mean any notice of policy discontinuance during the term of the policy where such discontinuance is initiated by the insurer, and shall not include discontinuances initiated by insureds.

Necessary Expenses as used in M.G.L. c. 152, §13A, shall mean all reasonable out-of-pocket costs, as the Department may set, to a claimant's attorney incurred by said attorney in prosecuting a claim for benefits or contesting a complaint filed by the insurer, including the cost of obtaining relevant medical records, doctor's reports, private investigator fees, constable charges, expert witness charges, interpreter fees and scientific testing costs, but specifically excluding telephone expenses, parking fees, postage, stationery, photocopies, meals, automobile expenses, and ordinary legal office overhead. Filing fees and impartial physician deposition costs required by M.G.L. c. 152, §11A, which are paid by claimant's counsel, shall not be submitted as necessary expenses but shall be reimbursable directly from the insurer against whom the claimant prevails at hearing.

180 Day Period as used in M.G.L. c. 152, §§8(1) and 8(6), shall mean the 180 day period beginning on the commencement of disability.

Payment of Compensation as used in M.G.L. c. 152, §41, shall include payments made without prejudice to the rights of either party.

Setting in Which the Service is Administered**,** as used in M.G.L. c. 152, §13(1) shall mean the physical location, including the jurisdiction and the type of facility, in which any health care service other than in-patient hospital service is administered.

Toll as used in M.G.L. c. 152, §41, shall mean permanently satisfies.

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1.06: Modification Or Discontinuance Of Compensation

ADD:

(1) Whenever the insurer or insured deems the employee to have refused to submit to, or in some way to have obstructed, a medical examination scheduled pursuant to M.G.L. c. 152, §§ 45 **and 11A**, it shall be entitled to suspend weekly benefits without an agreement, order, or decision. Such a suspension of weekly compensation shall take effect only after the Department is notified on a form prescribed by the Department and when the insurer sends a written notice of the suspension to the employee and the employee's legal counsel, if any, by certified mail with a copy of the notice also sent to the department. Suspension cannot be commenced until the date the notice is mailed. Such notice shall state the grounds for the suspension and, **except as to suspensions pursuant to M.G.L. c. 152, § 11A,** shall contain notification of the re-examination date. The re-examination shall be scheduled to occur not less than seven days nor more than 21 days from the date of notice of the suspension. Such notice shall also instruct the employee that attendance at, and cooperation with, the re-examination shall result in reinstatement of weekly benefits and payment of benefits withheld during the period of such suspension. Should the claimant fail to appear at the re-examination, or in any way obstruct, or fail to cooperate at such re-examination, the suspension shall continue until an administrative judge makes a determination whether benefits should be forfeited.

> **Purpose:** Proposed amendment will simply add § 11A(2) impartial medical examinations to this regulation, which presently allows for suspension and possible forfeiture of benefits in the event an employee fails to attend a § 45 insurer medical examination. The change in the fourth sentence reflects that the insurer does not schedule § 11A(2) medical examinations, which function is performed by the impartial unit of the DIA.

(2) No suspension of benefits shall be allowed on the basis of an employee's failure to meet with a vocational rehabilitative specialist within the Department pursuant to M.G.L. c. 152, § 45 without the written authorization of the Office of Education and Vocational Rehabilitation.
(3) An insurer seeking to discontinue benefits in accordance with M.G.L. c. 152, § 35E shall file a complaint in accordance with the provisions of M.G.L. c. 152, § 7G. An insurer may not unilaterally discontinue benefits under M.G.L. c. 152, § 35E.
(4) An insurer, without the requirement of an order under M.G.L. c. 152, § 10A, may suspend or take credit for any compensation due to the extent of any excess retained by or paid to an employee in connection with a settlement approved in accordance with the provisions of M.G.L. c. 152, § 15.

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1.07: Claims And Complaints

(1) A claim for compensation may be filed by any person, including an employee, dependent, physician, hospital or other health care provider, who believes that benefits are due under M.G.L. c. 152.

(2) Pursuant to the provisions of M.G.L. c. 152, §7(G), the following documentation must be attached to a claim for benefits, or complaint for modification or discontinuance of benefits before it will be processed by the Office of Claims Administration:

(a) Any claim for a recalculation of the compensation rate under M.G.L. c. 152, §1 shall be accompanied by one or more of the following:

1. an affidavit attesting to the reasons why the weekly rate is incorrect;
2. a wage schedule of the employee or an affidavit attesting that a demand for a wage schedule was made upon the employer, concurrent employer and/or insurer without success, together with a brief recitation of why the claimant alleges the average weekly wage is inaccurate and why the wage schedule is needed;
3. all relevant pay stubs;
4. a W-2 tax form or any of the above documents for a comparable worker where the employee has worked only a short time for the employer prior to the date of the injury.

Where concurrent employment is at issue, documentation as listed above shall be furnished for all concurrent employers, together with an affidavit attesting to the name of the concurrent employer and its insurer during the relevant period of concurrent employment.

AMEND:

(b) **1.** Claims for penalties under M.G.L. c. 152, §8(1) shall be accompanied by a copy of the order, decision, arbitrator's decision, approved lump sum or other agreement or other relevant documents(s) with which it is alleged the insurer has failed to comply, together with

an affidavit signed by the claimant or the claimant's attorney attesting to the date payment was due, the date, if any, on which payment was made, and the amount of penalty the claimant is owed.

the notice letter under subparagraph 2 below and an affidavit signed by the claimant or the claimant's attorney attesting to the date, if any, on which payment was made, and the amount of the penalty the claimant is owed.

ADD:

2. Notice by certified mail, return receipt requested, shall be served on the insurer that such insurer has failed to make any payments due an employee under the terms of an order, decision, arbitrator's decision, approved lump sum or other agreement, or certified letter notifying said insurer that the employee has left work after an unsuccessful attempt to return within the time frame determined pursuant to § 8(2)(a) within fourteen days of the insurer's

receipt of such document, pursuant to § 8(1).

3. **The § 8(1) schedule for increased penalties due as of forty-five, sixty and ninety days without payment shall be tolled until such notice is served.**

Purpose: The proposed changes and addition would add a reasonable notice requirement to the strictly construed penalty provisions of G. L. c. 152, § 8(1). See McCarthy's Case, 66 Mass. App. Ct. 541 (2006)(no good faith exception to § 8(1) penalties). It would simply require the employee/counsel to notify the insurer, after 14 days have elapsed since the receipt of an order of payment (as listed in the statute), to inform the insurer, by Certified mail, RRR, of its failure to comply with § 8(1), and that payment, plus the first $200 penalty, is due. With receipt of this notice, the schedule of graduated penalties commences to run. Absent the notice, the increased penalty provisions are inapplicable, as the schedule (45, 60 & 90 days) is tolled.

The regulation is intended to put an end to the practice of employee counsel sitting back for 90 days and waiting for the full $10,000 penalty to accrue, before making any overture to the insurer about its failure to pay on time. While it imposes this slight added burden on employee's counsel, it does so in recognition of the inequity of a deliberate accumulation of penalty dollars, which is not in the interests of any participants in the system.

(c) 1. Claims for payment for adequate and reasonable health care services shall, where applicable, be accompanied by the following:

a. the dates of service;
b. the type of treatment or service and the itemized costs;
c. office notes, hospital records, or a statement from the attending physician or medical vendor that such visit, testing, prescription drug, therapy, or ancillary medical service device or aid was reasonable, necessary, and causally related to the injury for which the employee is eligible for benefits.

2. Claims for mileage reimbursement necessarily incidental to the provisions of adequate and reasonable medical services shall be accompanied, where applicable, by the following:

(a). an itemized bill confirming the date and location of treatment;
(b). an affidavit from the claimant or claimant's attorney attesting to the exact mileage from the employee's home to the site of the treatment and back, and, except where the travel is incidental to an examination requested by the insurer or the department, the purpose of the treatment and reason for the trip;
(c). copies of parking receipts, cancelled checks or receipts, together with documentation from the provider except where the travel is incidental to an examination requested by the insurer or the Department, relating the service to the industrial injury and deeming it reasonable and necessary.
All bills presented shall, where possible, contain treatment codes, the percentage

of reimbursement to which the hospital is entitled and the provider's tax identification number.

(d) All claims for payment of an attorney's fee shall be accompanied by an order, decision, arbitrator's decision, lump sum or other agreement for compensation, or, where necessary, a memorandum outlining the circumstances giving rise to the entitlement of an attorney's fee under the appropriate section of M.G.L. c. 152, §§ 10B or 13A.

Where necessary expenses have not been paid, a memorandum shall also outline the nature and amount of the expenses and be accompanied by receipts or proof of expenditures.

Each claim shall be accompanied by an affidavit signed by the attorney attesting that payment of an attorney fee is owed and that the insurer has refused or neglected to pay the fee after being notified by certified mail that the fee and/or necessary expenses are owed and unpaid and that 14 days have passed since said notice was received.

(e) Claims for payment of funeral expenses shall be accompanied by an itemized funeral bill together with a copy of a death certificate.

((f) Claims for benefits under M.G.L. c. 152, § 31 shall be accompanied by a copy of a death certificate and the documentation required for filing a dependency benefit claim under M.G.L. c. 152, § 35A. Claims for benefits under M.G.L. c. 152, §§ 34, 34A and 35 shall be accompanied by a copy of a physician's report or record not more than six months old that describes the extent and duration of the employee's physical or emotional incapacity for work and which relates said incapacity to the claimed industrial injury.

(g) All claims for cost-of-living adjustments pursuant to M.G.L. c. 152, §§ 34B and 35F shall be accompanied by an affidavit attesting to the date of injury under which the employee is collecting weekly compensation, the present section of M.G.L. c. 152 under which benefits are being paid, and the date of eligibility for the commencement of the claimed cost-of-living adjustments.

This affidavit must be signed by the claimant or claimant's counsel. The claim must be accompanied by a signed release for the Social Security office on form CR-28 - (Commonwealth of Massachusetts Cost of Living Adjustment Data Form).

(h) In any claim in which M.G.L. c. 152, §35A is the only benefit claimed and where dependency is requested for dependents who are conclusively presumed to be dependent under M.G.L. c. 152, §35A, the claim shall be accompanied, where applicable, by a copy of one or more of the following:

1. the marriage license and a notarized statement from the dependent's spouse confirming that the spouse was living with the employee at the time of the injury;
2. birth certificates for each child under 18, or, if over 18, an affidavit attesting to the circumstances under which the child qualifies as a dependent under M.G.L. c. 152, §35A(c);
3. any court order or decree or court approved agreement requiring the employee to pay child support; or
4. an affidavit by a parent of an unmarried child under the age of 18 attesting to the parent's dependency upon the support of the child.

(i)

1. All claims for functional loss under the provisions of M.G.L. c. 152, §36 or §36A

shall include a physician's report which indicates that a maximum medical improvement has been reached and which contains an opinion as to the percent of permanent functional loss according to the American Medical Association's guide to physical impairment.

There shall also be a statement from the claimant, or the claimant's attorney or other authorized representative indicating the specific monetary value of the benefit award being sought as reflected by the opinion of the physician's accompanying report. No claim for functional loss may be filed sooner than six months following an injury or the latest surgery resulting from the injury.

2. All claims for scarring or disfigurement under M.G.L. c. 152, §36(k) or §36A shall be accompanied by a physician's report, operative note, or other hospital record, describing the area of scarring or disfigurement in detail, including its length, size, and exact location, and a signed written statement by the claimant or the claimant's counsel indicating the specific monetary value of the benefit award being sought.

The claimant or his counsel shall also include in the signed written statement a detailed description of the nature and quality of the scarring or disfigurement, including color of the scar, and whether or not it has visible stitch marks or other visible, anatomical deformities, or, in the alternative, a dated color photograph which is of reasonable clarity and which depicts a ruler, tape or other measuring device placed in proximity of the scar being claimed which can be clearly seen by someone viewing the photograph, showing the length of the scar being claimed.

No claims for scarring and disfigurement may be filed sooner than six months following the date of injury or the surgery which is the basis of the claim for scarring or disfigurement, except that disfigurement claims relating to limps or use of canes may not be filed before an end medical result has been reached.

(j) A complaint requesting modification or discontinuance of benefits made pursuant to M.G.L. c. 152, §10 shall be accompanied, where applicable, by the following documentation:

1. hospital medical records;
2. physician's report(s) opining work capacity which shall be no more than six months old;
3. an investigator's report or a synopsis which contains information indicating that the employee is working or exhibiting the capability of working, where the report is the sole basis for discontinuance;
4. wage records demonstrating employment of the employee during the period compensation was collected;
5. a job description of any work offered to the employee when accompanied by a medical report which contains a physician's opinion that the employee is capable of doing such work;
6. a brief memorandum or affidavit specifying the basis for the request to modify or terminate benefits.

(k) A complaint requesting recoupment pursuant to M.G.L. c. 152, § 11D(3) shall be accompanied by a copy of the decision of an administrative judge or court of the Commonwealth indicating that an overpayment has been made and an affidavit by the insurer attesting that weekly benefits are no longer being paid to the employee so that

unilateral reduction cannot be implemented.

(l) A claim requesting reimbursement under M.G.L. c. 152 §§ 37 and 37A shall be made on a form prescribed by the Department which shall be accompanied by both a certificate stating that it was served on the Office of Legal Counsel, and by a petition which sets forth and documents items which include, but are not limited to, the following:

1. Employee's job description and duties; educational, military, and employment history; and, vocational training prior to the "subsequent impairment" (i.e. compensable personal injury for which petitioner seeks M.G.L. 152, §§37/37A reimbursement; also known as "second injury.")

2. Evidence of employer's knowledge of employee's pre-existing physical impairment due to a previous accident, disease or congenital condition as evidenced by such documents as a job application, a pre-employment physical report, or by employer's affidavit attesting that employer knew of the impairment not later than 30 days after the date of employment, or (for injuries occurring prior to 12/23/91) by medical records which existed prior to the date of the subsequent impairment.

3. Evidence that a known pre-existing physical impairment was, or was likely to be, a hindrance or obstacle to employment (i.e. medical records evidencing permanent physical restrictions, documented job modifications or accommodations which the employer made on behalf of employee).

4 All medical records pertaining to the subsequent impairment including attending physician reports, insurance medical examinations, and DIA impartial physician report.

5. From the compensation claim involving the second injury, copies of all DIA documents which substantiate the reimbursements which the petitioner seeks, such as:

(a) Employee Claim Form (110)

(b) First Report of Injury

(c) Agreement(s) to Compensation

(d) Conference Orders, Hearing Decisions and Lump Sum Agreement

6. Indemnity record for all reimbursable compensation paid after the 104th week from the date of the onset of disability or death that clearly identify the claimant, the section under which compensation was paid, the dates for which payment was made, and the amount of weekly compensation.

7. Medical bills paid for all related reimbursable medical treatment received by employee after the 104th week from the date of the onset of disability. (Computer printouts which clearly identity the claimant, the service providers, and the dates of service constitute satisfactory documentation).

8. A description of the subsequent impairment which includes an authoritative medical statement as to how the subsequent impairment is substantially greater (by the combined effects of such impairment and subsequent personal injury) than the disability that would have resulted from the subsequent personal injury alone, or that the subsequent injury was caused by the pre-existing impairment, and, if death results from the subsequent injury, that the death would not have occurred except for such pre-existing physical impairment.

ADD:

(m) All claims and complaints alleging §§ 8 and/or 14 must specify the individual subsections under §§ 8(1), 8(5), 14(1) or 14(2) or the claim or complaint shall be administratively withdrawn.

Purpose: This offered change is necessary to provide adequate notice to the insurer or employee of the exact nature of the penalty being claimed. The investigation, discovery and decision to adjust may vary significantly depending on the subsection alleged. The present practice before the Board simply lists Section 8 and/or Section 14 on the Form 110 or Form 108 or via motion with no further particular breakdown.

ADD:

(n) Claims for penalties under M.G.L. c. 152, §8(5) shall be accompanied by an affidavit stating the penalty being claimed and the basis for the alleged claim.

Purpose: The intent of this regulation is to require particularization similar to that required for Section 8(1) claims in Rule 1.07(2)(b).

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1.09: Assignment To Division Of Dispute Resolution

(1) The referral fee under M.G.L. c. 152, §10, in each case in which the insurer fails to appear for a scheduled conciliation shall be 130% of the average weekly wage in the Commonwealth. All referral fees under M.G.L. c. 152, §10 shall be computed according to the average weekly wage in the Commonwealth at the time of payment.

(a) An insurer who is aggrieved by the assessment of a referral fee of 130% of the average weekly wage in the Commonwealth may seek an administrative review by the conciliation manager within 30 days of the issuance of the bill and shall include any relevant documentation with such request.

A conciliator's assertion that an insurer was absent for a scheduled conciliation shall be final, and the review shall be limited to the issues of whether the higher assessment was a mistake and, if not a mistake, whether the absence of the insurer was beyond such insurer's control.

Said manager shall make a finding within 30 days of receipt of a documented request for review.

(b) An insurer who is aggrieved by the finding of said manager shall have 14 days from receipt of said finding to request a hearing before the Commissioner or his designee, who shall schedule such hearing in Boston within 30 days of receipt of such request. At the hearing the employer shall be given the right to be represented by counsel. The issues at such hearing shall be limited to those that may be considered in the administrative review. The hearing shall not be subject to rules of evidence.

(c) No insurer shall be granted more than one administrative re- view for any referral of a case to the Division of Dispute Resolution.

(d) An insurer's obligation to pay a referral fee shall not delay the forwarding of the claim and the case to the Industrial Accident Board.

(2) At any time after the case has been assigned to the Industrial Accident Board, any party may petition the Commissioner for a stay of the proceedings for documented reasons beyond the control of such party or his attorney. On any such request, the Commissioner may grant a stay for no more than 60 calendar days. A list of all stays shall be compiled quarterly and shall be submitted to the advisory council.

(3) At any proceeding within the Division of Dispute Resolution, the burden of going forward shall be on the party seeking benefits or on the insurer seeking modification or discontinuance of benefits.

ADD:

(4) The responsibility for providing and paying for an interpreter when needed at the § 10A conference rests with the party that files the claim or complaint. Thereafter, responsibility for providing and paying for an interpreter, whenever one is needed, rests with the party appealing from the conference order. If both parties appeal from the § 10A conference order, the responsibility of providing and paying for such interpreter rests with the party that filed the claim or complaint.

Purpose: The purpose for Rule 1.09(4) is to provide clarification and consistency with respect to which party pays for an interpreter during the course

of proceedings before the Department. The Rule reflects § 1.09(3) as to the burden of going forward at the 10A Conference: The party who files the Claim or Complaint is responsible for providing and paying for the interpreter.

However, upon appeal of a Conference Order, the responsibility of providing and paying for the interpreter rests with the appealing party, as this party is moving the process forward and requiring the necessity of an interpreter at future proceedings.

In the event both parties appeal the Conference Order, then the responsibility of providing and paying for the interpreter rests with the party that filed the Claim or Complaint.

1.10: Conferences

(1) The administrative judge shall preside over the conference held pursuant to M.G.L. c. 152. §10A. Such conference shall be informal, and inquiries and investigations shall not be subject to the rules of evidence applied in this Commonwealth.

(2) The parties shall prepare for submission at the outset of a conference a memorandum setting forth the benefits claimed and the issues in dispute, the facts stipulated, the exhibits to be marked for identification, the names of witnesses to be presented, a summary of their anticipated testimony, the estimated length of the hearing, and such other matter as may be allowed or required.

Such memorandum may be amended by the parties, with the leave of the administrative judge, at or before the hearing. At a conference involving a medical issue, the parties shall also identify to the administrative judge as part of the required memorandum:

(a) the medical issue(s) in dispute requiring the filing of the requisite fee;

(b) a list of documents to be included in the medical records to be sent to an impartial physician; any hypotheticals or disclosure questions to be submitted to the impartial physician upon the judge's approval; identification of a specialty or the names of up to three impartial physicians in order of preference if agreed upon; and the names of any additional physicians anticipated to be requested at hearing to be deposed;

(c) any objection to the documents included in the medical records and hypotheticals to be submitted to the impartial physician.

(3) At a conference, the administrative judge shall make such inquiries and investigations as he deems necessary and shall have the power to require and receive reports of injury, signed statements of the employee and other witnesses, medical and hospital reports and records, and such other oral and written matter as shall enable him to determine whether weekly compensation or medical and hospital bills under M.G.L. c. 152 are due.

(4) No stenographic transcription or electronic recording shall be made of the conference proceedings under M.G.L. c. 152, §10A, except that the administrative judge, if he deems it to be in the interest of justice, may require such transcription or recording or, with the con- sent of all parties, may allow any party, at its own expense, to make a transcription or recording of the proceedings.

(5) No impartial physician shall be required in disputed matters concerning death and matters where the dispute over entitlement to weekly benefits concerns specific period(s) of prior disability.

AMEND:

(6) In disputes regarding
present disability where the parties agree upon both the partial nature and the duration of the disability as well as the causal relationship between the disability and the employment,
the extent of incapacity where the parties agree upon both the nature of the impairment as well as the causal relationship between the impairment and the employment,
subject to the provisions of M.G.L. c. 152, §11A(2) and 452 CMR 1.02, the parties may agree in writing at the time of conference that an impartial physician is not required.

(7) In claims where initial liability has not been established, subject to the provisions of M.G.L.

c. 152, §11A(2) and 452 CMR 1.02, the parties may agree in writing at the time of conference that an impartial physician is not required.
(8) In cases where no impartial physician is required the requisite fee pursuant to M.G.L. c. 152, § 11A(2) shall not be required.

ADD:

(9) No impartial physician shall be required where an administrative judge has determined, based upon the information submitted at the § 10A conference, that there is no dispute over medical issues and has so stated in the § 10A conference order.

Purpose: The committee has considered various situations where there may be a dispute over the degree of impairment or incapacity but the area of contention involves non-medical factors such as the employee's age, education, training, work experience or other vocational factors.

Situations arise whereby the parties submit medical reports identifying essentially similar physical restrictions making the need for an impartial medical examination unnecessary; or where one of the parties fails to submit any medical report, relying instead on a sec. 11A impartial medical examination. In both of these situations, an impartial medical examination would neither add anything new to the dispute resolution process nor resolve a dispute between "dueling doctors," the Legislature's rationale behind the enactment of sec. 11A.

The committee has also proposed amending Rule 1.10(6) to add a provision that would allow the parties to determine that a sec. 11A impartial report would not likely affect the determination of the degree of incapacity or duration of benefit entitlement, and to opt out of the impartial medical examination in cases involving only those issues. This proposal dovetails with subparagraph (c) above.

The committee has also proposed adding to Rule 1.10 a new paragraph (9) which would mirror the proposal for the subparagraph (d) above, allowing an administrative judge to determine at the 10A conference that the case does not present a medical dispute sufficient to warrant sending the case to an impartial medical examination.

ADD:

(10) In cases where multiple claims in the alternative have been filed against the same or other insurers for identical periods of disability and/or medical benefits and said claims after being heard at conference before an Administrative Judge result in an order for benefits being filed against one insurer and general order(s) of denial being filed in the alternative claim(s), then, if the insurer against whom the order is filed either does not appeal the order or withdraws its appeal prior to a hearing decision, the failure by the claimant to pursue an appeal of the order(s) of denial shall not constitute a general denial of liability.

Purpose: This Rule is intended to correct an unintended consequence of the reviewing board's decision in the case of Cerasoli v. Hale Development, 13 Mass. Workers' Comp. Rep. 267 (1999). In Cerasoli, the reviewing board ruled that where a claimant filed for compensation benefits against a single insurer who denied the claim and raised the issue of liability at the conference, a general order of denial which was not appealed (or was appealed and the appeal withdrawn before a hearing), forever foreclosed that claimant's right to file any new claims against the same insurer for the same injury. This finding was appropriate for the single claim against one insurer. (The reasoning for the result in Cerasoli has been recast as failure to prosecute, rather than res judicata. The conclusion, however, is unchanged. See Sanches v. Framingham State Hosp., 21 Mass. Workers' Comp. Rep. ___ (Feb. 8, 2007).)

Occasionally, however, a worker over the course of years may experience several separate injuries to the same body part and the insurer at the time of each injury might pay the employee temporary benefits without prejudice or the employee might miss five or fewer days from work making the injury a medicals only claim. In each of these instances, the insurer would not have accepted liability, and would be free to contest later claims for further disability periods raising liability as a defense whenever there are recurrences of the injury. In such circumstances the employee will usually file claims against each of the successive insurers so that all the claims are heard together before one administrative judge. This insures that when a determination is made regarding which of the several industrial accidents caused the new period of disability to occur, the administrative judge will have that insurer before him or her in order to make the appropriate order for benefits.

Under the law in Massachusetts, periods of disability cannot be apportioned between insurance companies. The judge can make an order for a particular period of disability against only one insurer at a time. Where claims are filed in the alternative against several insurers, only one insurer can be found responsible for paying benefits. All orders at conference are temporary orders unless none of the parties appeal. Thus, when an order is made against one insurer, who appeals the order, an impartial examination will usually take place and then a hearing will follow. It is quite conceivable that, at the time of the decision following the hearing, liability could be shifted from the insurer against whom the order was made at conference to one of the other insurers. Therefore, even where an order is entered at conference against one insurer, the employee is best advised to appeal the denials entered against all the alternative insurers.

The unintended consequence of the Cerasoli decision, occurs when the insurer against whom the order was made at conference decides to appeal the conference order and then withdraws its appeal prior to the hearing. Before the Cerasoli decision, the employee's counsel could have withdrawn his or her

appeals against the remaining insurers and no hearing would be necessary. However, where the insurers against whom a denial was entered at conference had raised the defense of liability at conference, the employee's counsel was left with a conundrum. To withdraw the appeal of the denial would, theoretically, trigger the application of Cerasoli and, forever bar any further claims being filed against that insurer, not only for the present period of disability being claimed, but also for any future periods of disability. This would be so even where all medical evidence pointed to causal relationship between a subsequent period of disability and that particular date of accident. This rule would avoid that conundrum and provide uniform guidance to all administrative judges faced with this situation.

1.11: Hearings

(1) Unless a late appeal is permitted by the Commissioner as provided by M.G.L. c. 152, §10A, any appeal from an order of an administrative judge must filed with the Department, on a form prescribed by the Department, not later than 14 calendar days from the filing date of said order.

(a) Where the appointment of an impartial examiner is required, a party has up to ten calendar days following the filing of the appeal to pay the Department the requisite fee. A request for a waiver of the requisite fee based on indigence shall be filed with the Commissioner on a form prescribed by the Department not later than ten calendar days following the filing of the appeal. Where more than one party files an appeal, each shall file timely either the requisite fee or a request for waiver on the prescribed form. The Department shall designate the first check received as the requisite fee required to schedule an examination by an impartial physician. All other checks will be returned.

(b) in a multiple insurer claim, all the individual appeal forms shall accompany a cover sheet approved by the Department which identifies all insurers and states the board number of each claim. One check payable to the Department in the amount of the requisite fee appended to the multiple appeal cover sheet with all individual appeal forms presented in a timely manner shall perfect all appeals;

(c) in any hearing conducted pursuant to M.G.L. c. 152, § 11, the parties may, consistent with 452 CMR 1.02, at the discretion of the administrative judge, agree in writing or on the record that an impartial physician is not required if such agreement has not been reached at Conference;

(d) in any hearing conducted pursuant to M.G.L. c. 152, § 11 where medical issues will be presented to an impartial physician all medical records will be marked for identification only.

(e) any hearing conducted pursuant to M.G.L. c. 152, § 11A(2) where medical issues have been presented to an impartial physician shall commence no sooner than one week after receipt of the impartial examiner's report by the parties including the Department.

ADD:

(f) In any hearing in which the insurer raises the applicability of the fourth sentence provisions of M.G.L. c. 152 , § 1(7A), governing combination injuries, the insurer must state the grounds for raising such defense on the record or in writing, with an appropriate offer of proof.

Purpose: The addition to the regulation is proposed to reflect the reviewing board's treatment of the fourth sentence of § 1(7A), the heightened causation standard, "a major but not necessarily predominant cause," applicable to injuries that involve combinations of non-compensable pre-existing injuries or diseases with an industrial injury or disease. The reviewing board has concluded that the insurer must raise the provision for it to apply to a proceeding. The employee is entitled, in other words, to fair notice of the insurer's intention to hold him/her to the heightened standard of causation. The regulation establishes what the reviewing board has stated in numerous cases over several years: An insurer has

the burden of production ("offer of proof" as stated in proposed regulation) as to information (most often, medical documents indicating a relevant pre-existing condition that reasonably could be seen as combining with the subject work injury) triggering the application of the provision at hearing. Where the insurer does nothing to make a showing of the possible application of the provision at hearing, the defense is waived. See, e.g., Jobst v. Grybko, 16 Mass. Workers' Comp. Rep. 125, 130 (2002); Fairfield v. Communities United, 14 Mass. Workers' Comp. Rep. 79, 83 (2000).

Once the provision is in the case, the employee has the burden 1) of proving causation to its heightened standard (industrial injury remains "a major cause" of disability or need for treatment), or 2) of attempting to defeat its application and remove it from the hearing, by establishing that one or more of its predicates is not met. See Viera v. D'Agostino Assoc., 19 Mass. Workers' Comp. Rep. 50 (2005).

(2) Except where events beyond the control of the Department make such scheduling impracticable, the same administrative judge conducting any conference held pursuant to M.G.L. c. 152, § 10A, shall preside over any hearing regarding the matter which is the subject of such conference.
(3) Before the taking of testimony in a hearing before an administrative judge, the insurer shall state clearly the grounds on which the insurer either has declined to pay compensation, or the grounds on which it seeks modification or discontinuance, provided that such statements are based on grounds and factual basis reported by the insurer or based on newly discovered evidence within the provisions of M.G.L. c. 152, §§ 7 and 8 and 452 CMR 1.00. On all other issues, the employee's rights under M.G.L. c. 152 shall be deemed to have been established.

ADD:

(4) At a hearing, any testimony of parties and witnesses before an administrative judge shall be given under oath or affirmation. Where the administrative judge finds that testimony should be given through any interpreter, the latter shall give oath to interpret faithfully and impartially. **All interpreters must be qualified, disinterested and suitable, unless the parties otherwise agree in writing.**

Purpose: The purpose for the addition to Rule 1.11(4) is to provide clarification and consistency with respect to the qualifications of an interpreter. Presently, the Rule does not specify that an interpreter must be qualified, only that the interpreter give an oath to interpret faithfully and impartially. On many occasions before the Department, a family member, friend or relative wishes to interpret for the Claimant. This leads to an issue with respect to whether the interpreter is qualified and impartial.

To address this issue, the proposal requires that the interpreter be a qualified, disinterested and suitable person. However, the parties may agree in

writing to use an individual, such as family member, relative or friend of the Claimant, who would not necessarily be “qualified, disinterested and suitable.”

(5) In all hearings before an administrative judge, the testimony of witnesses shall be taken orally or by deposition. Unless otherwise provided by M.G.L. c. 152, or 452 CMR 1.00, the admissibility of evidence and the competency of witnesses to testify at a hearing shall be determined under the rules of evidence applied in the courts of the Commonwealth. The decision of the administrative judge shall be based solely on the evidence introduced at the hearing.

(6) At a hearing pursuant to M.G.L. c. 152, § 11 in which the conference appeal was filed prior to July 1, 1992, or in which the case does not involve a dispute over medical issues as defined in 452 CMR 1.02 , or in which the administrative judge has made a finding under M.G.L. c. 152, § 11A(2) that additional testimony is required due to the complexity of the medical issues involved or the inadequacy of the report submitted by the impartial medical examiner, a party may offer as evidence medical reports prepared by physicians engaged by said party, together with a statement of said physician's qualifications. The administrative judge may admit such medical report as if the physician so testified, provided that where specific facts are in controversy, the administrative judge shall, on motion by a party, strike any part of such report that is not based on:

(a) the expert's direct personal knowledge;

(b) evidence already in the record; or

(c) evidence which the parties represent will be presented during the course of the hearing. Pursuant to 452 CMR 1.12(5) , any party may, for the purpose of cross-examination, depose the physician who prepared an admitted medical report. After such cross examination, the parties may conduct further examination pursuant to the rules of evidence applied in courts of the Commonwealth.

(7) The administrative judge shall preside over the hearing and shall control the conduct of parties, attorneys, and witnesses. Each party at a hearing may give a brief opening statement and closing argument, and may submit briefs, motions, requests for findings of facts, and requests for rulings of law, within such time as the administrative judge may prescribe. The administrative judge, at his discretion, may require the filing of briefs in such form and within such time as he may direct.

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1.12: Discovery And Depositions

(1) On or after the filing of any claim, the claimant may serve on any other party a request to be permitted to enter upon a designated area or areas of the employer's premises for the purposes of measuring, surveying, photographing, testing, sampling, or inspecting any designated object, record, or substance thereon.
(2) On or after the filing of any claim or complaint, any party may serve on any other party, employer or medical provider rendering treatment to the claimant, a request to produce, and permit the party making the request to inspect and copy, any medical notes, treatment reports and employment records to include but not be limited to record of wages earned subsequent to the alleged injury.

AMEND:

(3) Any request submitted under 452 CMR 1.12(1) or (2) shall set forth the item or category of items to be inspected, and describe each item or category with reasonable particularity. Such request shall be accompanied by a statement providing the relevance of the requested information to the instant case. The request shall specify a reasonable time, place, and manner of making the inspection and performing the related acts. The party on whom the request is served shall respond in writing within *five* **twenty** calendar days after service of the request. The response shall state, with respect to each item or category, that inspection and related activities will be permitted as requested, unless the request is objected to, in which event the reasons for objection shall be stated.

> **Purpose:** This change enlarges the timeframe for a party to respond to a Request for Production of Documents from 5 days to 20 days in recognition of the difficulty in responding within 5 days and the nearly universal failure of parties to adhere to the short timeframe.

ADD:

(4)**(a)** On written motion of an appropriate party, the administrative judge to whom the case has been assigned may require, by the issuance of any order, that any request for discovery, including any request submitted under 452 CMR 1.12(1) or (2), be complied with. Failure to comply with said order without good cause may result in assessment of costs or penalties pursuant to M.G.L. c. 152, § 14.

(b) Any motion relating to discovery must be served upon counsel for the opposing party and the administrative judge. The party receiving the motion shall, within ten (10) days of receipt of the motion, comply with the discovery sought by motion or provide a written response opposing the motion with specificity to the other party and the administrative judge. A hearing on the motion may be required at the discretion of the administrative judge. The administrative judge may rule upon the motion without hearing. All other motions not relating to discovery are exempt from this rule.

Purpose: This new section applies to discovery motions only. There is currently no specific procedure applicable to discovery motions. Discovery motions are sent to administrative judges requiring that the administrative judge determine if there is any opposition and if there is, to schedule a hearing to address the issue. This requires administrative judges and their assistants to make countless calls and schedule proceedings that may not be necessary. The new section establishes a procedure to be followed in the filing of any motion related to discovery. Discovery motions must be served upon opposing counsel and the administrative judge. A party has 10 days from receipt of the motion to either comply with the discovery request or file a written opposition specifying the basis of the opposition. The administrative judge has the discretion of requiring a hearing on the motion or may rule upon the motion without hearing. This section will provide all parties with the procedure to be followed and remove the burden upon the administrative judge to direct the procedural course of the discovery motion.

(5) (a) At a hearing pursuant to M.G.L. c. 152, § 11 in which the conference appeal was filed prior to July 1, 1992, or in which the case does not involve a dispute over medical issues as defined in 452 CMR 1.02, or in which the administrative judge has made a finding under M.G.L. c. 152, § 11A(2) that additional testimony is required due to the complexity of the medical issues involved or the inadequacy of the report submitted by the impartial medical examiner, an administrative judge may authorize the taking of testimony of medical witnesses by deposition. An administrative judge shall authorize the testimony by deposition of the impartial physician. The impartial physician's testimony may not be taken prior to the first scheduled M.G.L. c. 152, § 11 or 11A(2) hearing date as applicable unless authorized by the administrative judge. The administrative judge's authorization of a pre-hearing impartial physician deposition must be in writing. In addition to the impartial physician's deposition, an administrative judge may authorize the submission of medical testimony by deposition on motion by a party or on the judge's own initiative. The required finding on medical complexity and/or inadequacy of the impartial physician's report may be made by the administrative judge prior to the first scheduled M.G.L. c. 152, § 11 or 11A(2) hearing date as applicable. Upon a written request of a party, the administrative judge may authorize such additional medical testimony after receipt of the impartial physician's report due to inadequacy of the report or the complexity of the medical issues involved. The administrative judge's authorization of additional medical testimony must be in the form of a written finding that such testimony is required due to the complexity of the medical issues involved or the inadequacy of the report of the impartial physician. Additional medical testimony may only be authorized pursuant to 452 CMR 1.00.

(b) Notice of the date, time, and place of the deposition shall be provided to all opposing parties by certified mail not less than seven calendar days before the deposition. The deposition shall be taken for use as medical evidence only and shall be admissible, in whole or in part, in proceedings before an administrative judge. No deposition of an impartial physician may exceed three hours without the agreement of all parties, including the physician, or unless authorized in writing by the administrative judge on a

motion by a party. All depositions shall be submitted at the time requested by the administrative judge but no more than 60 calendar days from the close of lay testimony, provided that a party may motion the administrative judge for an extension for cause for no more than 30 calendar days. Any extension shall be authorized in writing by the administrative judge on motion by a party.

AMEND:

(c) Where an impartial medical examiner who has submitted his or her report is rendered unavailable, or makes him or herself unavailable for deposition, either party may file a motion seeking a ruling that the impartial medical examiner is unavailable. *A ruling of unavailability shall mean the impartial medical examiner's report is inadequate and that additional medical evidence shall be allowed.* **Unless the parties otherwise agree, a ruling of unavailability resulting from reasons other than those stated in G L. c. 152, § 20B, shall result in the striking from the record evidence of the impartial medical examiner's report, and a required ruling of inadequacy authorizing the parties to submit additional medical testimony**. Upon such a ruling, the administrative judge shall allow a reasonable extension of time for submission of such additional medical evidence, not to exceed 45 days. The impartial physician's submitted report, however, shall be admitted into evidence at the hearing and shall retain its prima facie character notwithstanding the finding of inadequacy.

> **Purpose:** The amendment reflects the reviewing board's treatment of impartial physician's reports, where the doctor is unavailable for cross-examination at deposition, which right is established in G. L. c. 152, § 11A(2). While the judge is allowed, by G. L. c. 152, § 20B, to accept into evidence the report of a deceased physician (treating or examining), in his/her discretion, any other unavailability of an impartial physician for cross-examination must render the report inadmissible. To rely on such a report could result in a due process violation, per the SJC's guidance in O'Brien's Case, 424 Mass. 16, 23 (1996). See Tejada v. Copley Square Hotel, 14 Mass. Workers' Comp. Rep. 220, 222 (2000); Martin v. Colonial Care Ctr., 11 Mass. Worker's Comp. Rep. 603, 606-607 (1997).

(6) Medical witnesses shall be informed, before the taking of their testimony by deposition, of their right to read and sign a transcription of their testimony, or of their right to waive such reading and signing. All objections to questions and all motions relevant to testimony shall be set forth with particularity, and with the reasons in support thereof, and no administrative judge shall be required to rule on any objection or motion unless such reasons or statements have been made.

ADD:

> **(7) An attorney for any party may serve a subpoena, issued by a Notary Public, or by a Justice of the Peace, stating the title of the action, name of the administrative judge, and shall command each person to whom it is directed to attend and give testimony or produce documents at a time and place therein specified. The Notary**

Public or Justice of the Peace shall issue a subpoena or a subpoena for the production of documentary evidence, signed but otherwise in blank, to a party requesting it, who shall fill it in before service. A subpoena may also command the person to whom it is directed to produce books, papers, documents or tangible things designated therein, but the administrative judge, upon motion at or before the time specified in the subpoena for compliance therein, may:

1. Quash or modify the subpoena it if is unreasonably oppressive; or beyond the scope of discovery or seeks documents protected by privilege; or

2. Condition denial of the motion upon the advancement of the person in whose behalf the subpoena is issued of the reasonable cost for producing the books, papers, documents or tangible things.

Notice of the subpoena must be given to counsel for each party to the action at least two business days prior to service. At the option of the party, a subpoena commanding the production of documents or other tangible things may include a provision stating that for the convenience of the witness and in lieu of appearance at the proceeding, the requested documents may be provided at a date, time and place specified in the subpoena. Any party receiving documents or other tangible things in response to a Subpoena shall provide a complete copy of the response to all parties to the action prior to commencement of the proceeding. Any documents obtained by subpoena not in compliance with this regulation shall not be admissible in any proceeding except by agreement of the parties, or as allowed by the administrative judge for just cause. Failure to comply with this regulation may subject the attorney to the provisions of G.L. c. 152, Section 14.

Purpose: This new section addresses many problems that have arisen in the service of subpoenas. The statute provides the administrative judge with the authority to subpoena witnesses and documents as they relate to any question before the administrative judge. In practice, attorneys have routinely issued subpoenas to compel the attendance of witnesses and to produce documents including, but not limited to, medical records. This section clarifies that an attorney may cause to be served a subpoena to compel the attendance of witnesses at a hearing and may serve a Subpeona Duces Tecum to compel the production of documents at a proceeding.

The proposed section requires that notice of the subpoena must be given to each party at least two business days prior to service. This is necessary due to the problem that currently exists of no notice of a subpoena being given to opposing counsel. Opposing parties are frequently unaware that subpoenas have been served and may only learn of a subpoena if the medical provider or other person receiving the subpoena notifies the attorney or the party.

The proposed section also requires the party receiving documents or tangible

	things in response to a subpoena to provide a complete copy of the response to all parties to the action prior to the commencement of the proceeding. Recognizing that abuse of the subpoena may occur, the proposed section allows a party to file a motion to quash or modify a subpoena if it is unreasonably oppressive; beyond the scope of discovery or seeks privileged documents. The proposed section specifies that any documents not obtained in compliance with the section shall not be admissible unless the parties agree to their admissibility. In order to require compliance with this section any attorney not complying may be subject to the provisions of Section 14. Standard form subpoenas will be available on the Department website to be used by attorneys.

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1.14: Impartial Physicians

(1) If within ten calendar days of filing the appeal the parties have not selected, or an administrative judge has not appointed, a physician from the impartial physician roster to examine the employee, the impartial unit shall choose a physician as directed by the Senior Judge.
(2) Once the impartial physician has been selected or appointed, the administrative judge shall submit to the impartial unit all approved medical records, any hypothetical fact patterns and any stipulations of fact for transmission to the impartial physician. No party or representative may initiate direct, ex parte communication with the impartial physician and shall not submit any form of documentation to the impartial physician without the express consent of the administrative judge.
The impartial physician may not communicate with the parties unless authorized to do so by the administrative judge, except that a party who wishes to engage the impartial physician to be deposed for the purposes of cross examination may contact the physician or his office for the purpose of scheduling a deposition.
The impartial physician may request medical records and reports from providers who have treated the employee prior to the date of the selection or appointment of the impartial physician. Providers of diagnostic services and testing shall send these records directly to the impartial physician upon request of the impartial physician or of the impartial unit.

ADD:

> **Except by leave of the administrative judge, hypothetical questions to the impartial physician must be submitted to the administrative judge within 14 days of the appeal of the conference order.**
>
> > **Purpose:** The proposal aims at establishing a consistent time frame for submission of hypothetical questions to the impartial physician.

(3) The filing fee paid pursuant to M.G.L. c. § 11A(2) shall be reim- bursed by the Department to each appellant if the parties have agreed pursuant to 452 CMR 1.11(1)(d) that an impartial physician is not required or the matter is resolved by the parties prior to the scheduled impartial examination. Any fee required to be paid to an impartial physician for cancellation of a scheduled impartial examination shall be deducted equally from each appellant's reimbursed filing fee.
(4) A party requesting the appointment of an impartial physician by the Senior Judge under the provisions of M.G.L. c. 152, §8(4) shall be responsible for payment to the impartial physician for the procurement of a report in an amount consistent with criteria developed by the health care services board pursuant to M.G.L. c. 152, §13.
(5) Any payment made by a party to an impartial physician appointed by the Senior Judge under the provisions of the second paragraph of M.G.L. c. 152, §8(4) shall be reimbursed by the insurer if the report determines that the particular course of medical treatment claimed was appropriate.
(6) Parties precluded by 452 CMR 1.00 from procuring the appointment of an impartial medical examiner under M.G.L. c. 152, 11A(2) may, by agreement, petition the administrative

judge having jurisdiction over the case for the appointment of an impartial physician. If the petition is granted, said impartial physician shall be paid an amount consistent with that approved by the Commissioner under M.G.L. c. 152, §11A(3) by, or amongst, any of the requesting parties.

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1.15: Reviewing Board

(1) Notice of Appeal. Any appeal from a decision of an administrative judge must be filed with the Department on the form prescribed by the Department not later than 30 days from the filing date of the decision, unless a late appeal is permitted by the Commissioner as provided by M.G.L. c. 152, §11C. A copy of the appeal shall be served by mail or in hand on counsel for each party or on each unrepresented party.

(2) Filing Fee. The filing fee or a request for its waiver shall be submitted to the Reviewing Board with the notice of appeal. The filing fee prescribed by M.G.L. c. 152, §11C shall be 30% of the average weekly wage in the Commonwealth at the time of payment. Any request for a waiver of the filing fee based on indigence shall be filed on a form prescribed by the Department.

(3) Reviewing Board. An administrative law judge may require counsel or pro-se litigants to appear for a conference to consider waiver of the filing fee, simplification of the issues on appeal, whether oral argument will be held, and any other matters that may aid in the disposition of the appeal.

ADD:

(4) Briefs. Unless otherwise ordered by the Reviewing Board, a brief shall be filed by the appellant in all cases in accordance with the following provisions:

(a) Content: The brief of the appellant shall contain under appropriate headings and in the order here indicated:

1. A statement of the issues presented for review; **stated with particularity. A statement that the decision on review is beyond the scope of the administrative judge's authority, arbitrary or capricious, or contrary to law, without more, shall not constitute a proper statement of the issues presented for review.**
2. A statement of the case, which shall first indicate briefly the nature of the
2. A statement of the case, which shall first indicate briefly the nature of the case, the course of proceedings and its disposition following conference and hearing. There shall follow a **brief** statement of the facts relevant to the issues presented for review, with appropriate references to the record;
3. The argument, which shall contain the contention of the appellant with respect to the issues presented, supporting rationale and citations to the authorities, statutes, rules, regulations and parts of the record on which the party relies. The Reviewing Board need not decide questions or issues not argued in the brief. If oral argument is permitted, nothing argued in the brief shall be deemed to be waived by a failure to argue the issue orally;
4. A short conclusion stating the precise relief sought; and
5. The names, addresses and telephone numbers of counsel and their firms.

ADD:

(b) Length and Form of Briefs: All briefs and appendices shall be produced as follows:

1. **Except by permission of an administrative law judge, briefs shall not exceed thirty pages, exclusive of pages as may contain a table of contents, tables of citations and any addendum containing statutes, rules or regulations. Permission shall not be granted unless the moving party specifies the relevant issue or issues and why such issues merit additional pages.**
2. **All briefs and appendices shall be produced by any duplicating or copying process that produces a clear black image on white paper, which shall be eight and one-half inches in width and eleven inches in height. The top, bottom, left and right margins shall be at least one inch. The typeface shall be 12 point Courier font or larger size and not exceeding 10.5 characters per inch. Text shall be double-spaced, except that argument headings, footnotes and indented quotations shall be single-spaced. The text may appear on both sides of the page, but the numbered pages of text shall not exceed the page limit set for the brief.**
3. **An administrative law judge may, on behalf of the reviewing board, accept briefs filed which are not in substantial compliance with these rules.**

(**c**) Statutory Provisions. If determination of the issues presented requires consideration of statutory provisions, rules or regulations, or when an appeal involves the application of amendments to M.G.L. c. 152, the parties shall reproduce all relevant sections of the original act and any later amendments, including all provisions regarding applicability and effective dates.
(**d**) Citations. References to decisions and other authorities shall include, in addition to the page at which the decision or section begins, a page reference to the particular material on which reliance is placed, and the year of the decision or other authority.
(**e**) Amicus Curiae. An amicus curiae shall notify the Reviewing Board of its intention to file a brief.
(**f**) Response Briefs. The brief of the appellee, cross-appellant, or amicus curiae shall conform to 452 CMR 1.15(4)(a-**b**) with the exception that a statement of issues *and/or facts* shall not be made unless the appellee or amicus curiae is dissatisfied with the statement of the appellant.
(**g**) Designation of Parties. In their briefs and oral arguments, counsel shall keep to a minimum references to parties by such designations as "appellant" and "appellee," instead using the designation used in the administrative judge's decision, the actual names of the parties, or descriptive terms such as "the employee", "the employer," and "the insurer".
(**h**) Time For Filing. Appellant shall file its brief 30 days after receipt of notification from the Reviewing Board that it is due. The appellee, cross-appellant or amicus curiae shall file its brief within 20 days of receipt of the appellant's brief. A reply brief may be filed by the appellant 20 days thereafter. No further briefs shall be filed without leave of the Reviewing Board. When there are cross-appeals, the party that files its appeal first shall be considered the appellant for the purpose of complying with the time requirements for the filing of briefs.

(**i**) Extension of Time. A request for an extension of time to file a brief shall be filed in writing with the Reviewing Board and shall state the length of extension requested and the specific reason for the request.
(**j**) Copies of Briefs. The original and four copies of each brief shall be filed with the Reviewing Board unless the Reviewing Board by order shall direct a different number to be filed. One copy shall be served by mail or in hand on counsel for each party or on each unrepresented party.

> **Purpose:** The proposal seeks to focus the presentation of issues argued in briefs to the reviewing board by putting more emphasis on specific delineation of the issues presented. By adding that the statement of facts should be "brief," the proposal emphasizes that the factual presentation should indeed be "relevant to the issues presented for review."
>
> The proposal also seeks to make more uniform the format of briefs filed at the reviewing board, and encourages crisp and concise argument by setting a thirty page limit. Although the proposal draws heavily from the M.R.App.P. 16, it does not set that rule's "extraordinary" reason requirement for the allowance of additional pages, as long as a party specifies why the issues presented warrant such.

(b) Statutory Provisions. If determination of the issues presented requires consideration of statutory provisions, rules or regulations, or when an appeal involves the application of amendments to M.G.L. c. 152, the parties shall reproduce all relevant sections of the original act and any later amendments, including all provisions regarding applicability and effective dates.
(c) Citations. References to decisions and other authorities shall include, in addition to the page at which the decision or section begins, a page reference to the particular material on which reliance is placed, and the year of the decision or other authority.
(d) Amicus Curiae. An amicus curiae shall notify the Reviewing Board of its intention to file a brief.
(e) Response Briefs. The brief of the appellee, cross-appellant, or amicus curiae shall conform to 452 CMR 1.15(4)(a) with the exception that a statement of issues shall not be made unless the appellee or amicus curiae is dissatisfied with the statement of the appellant.
(f) Designation of Parties. In their briefs and oral arguments, counsel shall keep to a minimum references to parties by such des- ignations as "appellant" and "appellee," instead using the designation used in the administrative judge's decision, the actual names of the parties, or descriptive terms such as "the employee", "the employer," and "the insurer".
(g) Time For Filing. Appellant shall file its brief 30 days after receipt of notification from the Reviewing Board that it is due. The appellee, cross-appellant or amicus curiae shall file its brief within 20 days of receipt of the appellant's brief. A reply brief may be filed by the appellant 20 days thereafter. No further briefs shall be filed without leave of the Reviewing Board. When there are cross-appeals, the party that files its appeal first shall be considered the appellant for the purpose of complying with the time

requirements for the filing of briefs.

(h) Extension of Time. A request for an extension of time to file a brief shall be filed in writing with the Reviewing Board and shall state the length of extension requested and the specific reason for the request.

(i) Copies of Briefs. The original and four copies of each brief shall be filed with the Reviewing Board unless the Reviewing Board by order shall direct a different number to be filed. One copy shall be served by mail or in hand on counsel for each party or on each unrepresented party.

(5) Dismissal of Appeal. The Reviewing Board may dismiss an appeal or cross-appeal for the following reasons:

(a) Failure of the appellant, without good cause, to file a brief, unless filing has been waived by the Reviewing Board;

(b) Failure of the appellant or cross-appellant to submit a filing fee or a fee waiver form;

(c) Failure of the appellant or cross-appellant to appear at oral argument without good cause.

(6) Oral Argument. If it elects to hear oral argument, the Reviewing Board shall advise all parties and any amicus curiae of the time and place of hearing. A request for postponement of the argument shall be made by motion filed reasonably in advance of the date fixed for hearing. The appellant shall argue first. Each party shall be allowed 15 minutes for argument unless the time is extended or limited by the Reviewing Board. In advance of oral argument, a party may request additional time, which will be granted only under unusual circumstances.

(7) Withdrawal of Appeal. The parties to any case pending before the Reviewing Board shall notify the Reviewing Board in writing of any settlement, withdrawal of appeal, adjustment or other disposition.

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1.18: Practice Before The Department

(1) Any attorney admitted to practice before the courts of the Commonwealth may practice before the Department.
(2) In any proceeding before the Department, any person not admitted to practice before the courts of the Commonwealth may appear and act for himself, or for a partnership of which he is a member, or for a corporation of which he is an officer, or for anybody from whom he has written authorization to represent on file with the Department on a form prescribed by the Department.
(3) An attorney, or other authorized representative may, without leave, withdraw as representative by filing a written notice of withdrawal, with copies to all parties, provided that such notice is accompanied by the appearance of a successor representative. Under all other circumstances, leave of the administrative judge, or administrative law judge having jurisdiction over an active proceeding must be obtained. In cases where no judge has active jurisdiction leave must be obtained from the office the senior judge.

AMEND:

(4) *Notice of any change of attorney or other qualified representative shall be given promptly, in writing, to the Department.*

Whenever an attorney appears at a proceeding, who:

a.) is not the attorney of record, or

b.) is not an attorney who, pursuant to his or her registration with the Board of Bar Overseers, shares the same business/professional address as the present attorney of record,

the attorney must file a written notice of appearance on a form prescribed by the Department prior to addressing the board in the proceeding. Where more than one attorney has filed an appearance for a party, all notices will be sent to the attorney who most recently appeared. In all cases, any attorney or qualified representative so appearing, is representing to the Department that she or he possesses full authority to handle any and all aspects of the matter presently pending at the Department.

Purpose: The regulations pertaining to practice before the department, are extremely broad. Although the present regulation sufficiently addresses the issue of an attorney's withdrawal of representation, the addition of an attorney to a case, or attorney appearances, have not been adequately addressed. As a result, it is not uncommon for attorneys practicing out of different offices to appear on behalf of a party at any given stage in the dispute resolution process. When multiple attorneys from different offices appear on behalf of a party, there becomes confusion as to where notices of proceedings and other correspondence should be sent. As a result, administrative judges have had difficulty securing the attendance of counsel for motion hearings and §11 hearings. Such absences not only impair the efficient adjudication of disputes but also result in the department expending scarce administrative resources to locate appropriate counsel. The proposed regulation seeks to remedy this situation. In addition,

the proposed regulation seeks to ensure that attorneys who appear at any scheduled event have the full authority to act on behalf of the respective party so as to enter into compromises of claims as counsel, on all department forms including, but not limited to, Form 113 Agreements to Compensate, Form 117 Lump Sum Settlement Agreements, and Section 19 Agreements.

(5) The Department may, for cause, deny or suspend the right of any person to practice before it.

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1.19: Payment Of Attorney Fees

(1) Where an attorney's fee is paid by the insurer pursuant to M.G.L. c.152, § 13A, that shall be the only fee permitted and no additional fee shall be charged by the attorney for such services. When the employee's attorney and the insurer agree on a fee and expenses, such fee and expenses shall be deemed to be approved by the administrative judge or Reviewing Board as the case may be. When the employee's attorney and the insurer are unable to agree, the administrative judge or Reviewing Board to whom the case was assigned shall determine the appropriate fee pursuant to M.G.L. c. 152, § 13A.

(2) An employee and his attorney may agree on a retainer, but only to pay for necessary and reasonable expenses and disbursements related to his representation. Any employee's attorney entitled to a fee paid by the insurer under M.G.L. c. 152, § 13A, shall provide the administrative judge or Reviewing Board with an itemization of any necessary and reasonable expenditures and disbursements related to his services, including expenses and disbursements paid by the employee. The insurer shall reimburse the employee for any such expenses or disbursements approved by the administrative judge or the Reviewing Board.

(3) When an insurer, at least two days before a conference, or at least five days before a hearing, serves on a claimant or person receiving compensation or the representative of such claimant or person a written offer to pay weekly compensation or compensation under M.G.L. c. 152, §§ 30 or 36, and such offer is not accepted, the insurer shall not be required to pay any fee under M.G.L. c. 152, § 13A, for such conference or hearing, unless the order or decision rendered directs a payment of said weekly or other compensation in excess of that offered. Such an offer may be to pay weekly compensation in an amount less than the amount being paid at the time the offer is tendered provided that, if the compensation is being paid pursuant to M.G.L. c. 152, § 8, and the insurer has a workers' compensation policy in effect for the policy year period in which the offer is made with the employer where the alleged injury occurred, then a wage statement signed by said employer indicating the average weekly wage at the time of such alleged injury shall be attached to the written offer of payment.

(4) In any proceeding before the Division of Dispute Resolution, the claimant shall be deemed to have prevailed, for the purposes of M.G.L. c. 152, § 13A, when compensation is ordered or is not discontinued at such proceeding, except where the claimant has appealed a conference order for which there is no pending appeal from the insurer and the decision of the administrative judge does not direct a payment of weekly or other compensation benefits exceeding that being paid by the insurer prior to such decision; or

ADD:

(5) For purposes of M.G.L. c. 152, § 13A(5), withdrawal by an insurer at or after the hearing shall constitute withdrawal within five working days of the date set for a hearing pursuant to M.G.L. c. 152, § 11. **For purposes of M.G.L. c. 152, § 13A(5), the employee shall be deemed to have prevailed when an insurer's § 14 fraud complaint is denied and dismissed.** For purposes of M.G.L. c. 152, § 13A(6), an employee shall be considered to have prevailed before the Reviewing Board if an insurer has withdrawn after an appeal for review has been filed under M.G.L. c. 152, § 11C.

Purpose: The addition to the regulation is proposed in order to reflect the holding of Richards's Case, 445 Mass. App. Ct. 701 (2004), which affirmed the reviewing board's award of an attorney's fee under § 13A(5) for an employee's successfully defending against an insurer's complaint for fraud under § 14(2). Section 13A(5) provides for a fee whenever an employee "prevails" at hearing. The reviewing board had refused to apply the restrictive language of 452 C.M.R. §§1.19(4) and (5), which only provided for a § 13A(5) "prevailing" "when compensation is ordered or is not discontinued." Because that language would have "contradict[ed] the scope and generality of the plain language of [§ 13A(5)]" the Appeals Court agreed that the "regulation [was] inapplicable to cases such as this, in which the insurer seeks but fails to achieve substantial penalties against the employee." Richards, supra at 706.

(6) Nothing in 452 CMR 1.19 shall affect fees paid to an attorney by an employee for services other than those rendered an employee under M.G.L. c. 152.
(7) For the purpose of computing attorneys' fees under M.G.L. c. 152, § 13A, and these rules, the average weekly wage in the Commonwealth shall be such wage on the date the order or decision is rendered, or the date the insurer accepts the claim or withdraws its request for modification or termination.
(8) For injuries occurring before November 1, 1986, fees of attorneys for representation of employees under M.G.L. c. 152 shall be subject to the approval of an administrative judge or Reviewing Board. If the employee and attorney cannot agree as to the attorney's fee, either party may notify the Division of Dispute Resolution which shall assign the case for a conference and/or hearing.

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